4. For costs not subject to standards, the cost determined in step 2 will be allowed in determining the facility's rate.

5. Accumulate costs determined in steps 3 and 4.

6. Inflate the cost in step 5 by multiplying the cost in step 5, by the inflation factor. The maximum inflation factor that can be used will be that provided by the State of South Carolina Division of Research and Statistical Services and is determined as follows:

   a. Proxy indices for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.) during the third quarter of 1999 were weighted by the expenditure weights of the long term care facilities. These eleven weighted indices are summed to one total proxy index for the third quarter of 1999.

   b. Proxy indices are estimated for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.), during the third quarter of 2000 and then weighted by the same expenditure weights as in step a. These weighted proxy indices were summed to one total proxy index for the third quarter of 2000.

   c. The percent change in the total proxy index during the third quarter of 1999 (as calculated in step a), to the total proxy index in the third quarter of 2000 (as calculated in step b), was 3.0%. Effective October 1, 1999 the inflation factor used was 3.0%.

7. The per patient day cost of capital will be calculated by dividing capital cost as determined under IF(C) of this plan by actual patient days. However, if the facility has less than 97% occupancy, actual days will be adjusted to reflect 97% occupancy.

8. Cost Incentive - General Services, Dietary, and Laundry, Housekeeping, and Maintenance

   If the facility's actual allowable costs for these three cost centers are below the sum of these three allowable cost standards, the facility will be eligible for a cost incentive of an amount equal to the difference between the sum of the standards and the sum of the facility's actual costs, up to 7% of the sum of the standards.

9. Profit will be allowed if the provider's allowable cost is lower than the standard as follows:

a. Administration and Medical Records & Services - 100% of difference with no limitation.

Ceiling on profit will be limited to 3 1/2% of the sum of the provider's allowable cost determined in step 2. The sum of the cost incentive and the profit cannot exceed $1.75 per patient day.

10. Effective December 1, 1998, an additional add on of $.75 per patient day will be provided in order to assist nursing facilities in retaining current nurse aide staff and comply with South Carolina's new nurse aide staffing requirements effective January 1, 1999 as defined on page 14.

11. Effective October 1, 1999 a CNA vacancy add on will be included in each qualifying facility's reimbursement rate. This add on will be provided to address the industry wide nurse aide staffing turnover problem, and is described on pages 14 through 17.

12. For rates effective October 1, 1999, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive, profit, CNA vacancy add on, and nurse aide add on of $.75 per patient day.

D. Payment for Hospital-based and Non-profit Facilities

Hospital-based and non-profit facilities will be paid in accordance with Sections III A, B, and C.

E. Payment determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets, change of ownership through a lease of fixed assets, when a facility changes its bed capacity by more than fifty percent (50%), or when temporary management is assigned by the state agency to run a facility.

The following methodology shall be utilized to determine the rate to be paid to a new facility; a replacement facility; a new owner, where a change of ownership has occurred through a purchase of fixed assets; a new owner, where a change of ownership has occurred through a lease of fixed assets; or when a facility changes its bed capacity by more than fifty percent (50%). Facilities which decertify and recertify nursing facility beds that results in a change in its bed capacity by more than fifty percent (50%) will not be entitled to a new budget.

A change in ownership will be defined as a transaction which results in a new operating entity. A purchase of the leased fixed assets by a lessee (owner of operating entity) will not be considered a change of ownership unless

allowable Medicaid capital costs will be reduced (i.e., purchase price less than historical costs). Each change of ownership request will be reviewed individually to determine whether a six month cost report will be required. Effective November 22, 1991, to qualify for a "new facility rate" based upon a six month cost report under a change in ownership, a sale or lease of assets between unrelated parties must occur. A new operator who leases a facility from a related party will not be entitled to a "new facility rate". Also, facilities in the process of obtaining a certificate of need due to a sale or lease between related parties prior to November 22, 1991 will be grand-fathered in under the existing system.

In the calculation of the rate effective the first and seventh month of operation, the Medicaid agency will determine the percent of Level A Medicaid patients served as follows:

a) For a facility which increases its bed capacity by more than fifty percent (50%), or a brand new facility entering the Medicaid Program, the percent of Level A Medicaid patients served will be based on the last month of the six month cost report.

b) For a replacement facility or a change in ownership, the Medicaid agency will use the most recent twelve months of data (See Page 19, Paragraph B-1 (e) for time periods) as reflected on the SCDHHS Aries report to establish the rates.

1) Rate determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets or when a facility changes its bed capacity by more than fifty percent (50%).

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid Agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate except that all standards to be used will be one hundred twenty-one percent (121%) of the standards for the size of facility to adjust for lower initial occupancy. The 121% adjustment to the standards for lower initial occupancy will only apply to the following facilities:

a) Brand new (newly constructed) facilities entering into the South Carolina Medicaid Program.

b) An existing facility in the South Carolina Medicaid Program which increases total beds by more than 50%.

The one hundred twenty-one percent (121%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-seven percent (97%) occupancy required for all facilities who have been in operation for more than six (6) months.

Therefore, existing facilities where there is a change in ownership through a purchase of fixed assets, or a replacement facility, will follow the same rate setting method as described in Section III C of this plan, with the exception of inflation. No inflation adjustment will be made to the first six (6) months cost.

Within ninety (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical Report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date. This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. Payment for the first six months will be retrospectively adjusted to actual costs not to exceed the standards. For new facilities and existing facilities that have increased their total beds by more than fifty percent (50%), the actual cost will be limited to 121% of the standards.

A new prospective rate, based on the Uniform Financial and Statistical Report, will be determined using the methodology as previously stated in section III C of this Plan. This new rate will be retroactively effective on the first (1st) day of the seventh (7th) month of operation under the program. However, in the case of the seventh (7th) month of operation through the September 30 rate for a new facility, or a facility which changes its bed capacity by more than fifty percent (50%), the per diem costs effective July 1, 1994 will be adjusted to reflect the higher of:

a) Actual occupancy of the provider at the last month of the initial cost report; or

b) Average occupancy of nursing facilities who are new or increase bed size by more than 50%. The average occupancy will be determined based on the last month of the initial cost report period of each type provider identified above (i.e., new facilities and facilities which increase bed size by more than 50%) over the last eighteen month period. A minimum of 10 nursing facilities will be required for this analysis. If 10 nursing facilities are not available over the preceding eighteen month period, then the eighteen month period will be extended; or

c) 90% occupancy.

2. <u>Rate determination for a change in ownership through a lease of fixed assets.</u>

In the event of a lease of fixed assets between unrelated parties, the new operator (i.e., lessee) will receive the prior operator's rate (i.e., lessor) for the first six full calendar months of operation. For a lease effective on October 1, the State agency will determine the new operator's rate based upon the prior year's cost report filed by the prior operator

on January 1. The new operator's rate for the first six full calendar months of operation will not be affected by any subsequent audits of the prior operator's cost report which was used to set the rate. In the event that the initial six full calendar months rate period crosses over into a new rate setting period effective October 1, the new operator will be entitled to receive a rate increase based upon the industry allowed inflation factor, plus any industry wide approved add on, if applicable.

For clarification purposes, we intend to use the prior operator's most recently filed and available FYE September 30 cost report to calculate the new operator's rate effective October 1 of each rate cycle during the initial six full calendar month rate period. Depending upon which most recently filed cost report is available will dictate the method used to determine the October 1 rate during the initial six full calendar month rate period (i.e. the October 1 rate during the initial six full calendar month rate period will be the prior owner's September 30 rate inflated, or the October 1 rate that the prior owner would have received if no change of ownership had taken place).

Effective the seventh month of operation, the new operator will be entitled to a new rate based upon his actual cost. The rate calculation for the new operator, based upon his actual costs, will be made in accordance with the rate setting method as described under Section III C of this plan. The actual cost report that will be filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends on September 30, provided that this time period includes at least six full calendar months of operation. In other words, if the lease is effective between October 1 and March 31, the cost report filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends on September 30. If the lease is effective between April 1 and September 30, the cost report filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends after six full calendar months of operation by the new operator. This cost report will be due within ninety (90) days after the end of the cost reporting period; however, a thirty (30) day extension can be granted for good cause. This cost report will determine a rate which will be effective retroactive to the new operator's seventh month of operation.

3. <u>Rate determination for a facility in which temporary management is assigned by the state agency to run the facility.</u>

In the event of the Medicaid agency having to place temporary management in a nursing facility to correct survey/certification deficiencies, reimbursement during the time in which the temporary management operates the facility will be based on 100% of total allowable costs subject to the allowable cost definitions set forth in this plan, effective October 1, 1990. These costs will not be subject to any of the cost standards as

reflected on page 4 of the plan. Capital reimbursement will be based on historical cost of capital reimbursement in lieu of the Medicaid agency's current modified fair rental value system. Initial reimbursement will be based on projected costs, with an interim settlement being determined once temporary management files an actual cost report covering the dates of operation in which the facility was being run by the temporary management.

This report will be due within ninety (90) days after the end of the period of operation. Once new ownership or the prior owner begins operation of the facility, reimbursement will be determined as previously described for a new owner under paragraph E (1).

F. Payment for State Government Nursing Facilities and Institutions for Mental Diseases

Because State Government facilities operate on budgets approved by the General Assembly and overseen by the Budget and Control Board, State Government nursing facilities and long term care IMD's will be paid retrospectively their total allowable costs subject to the allowable cost definitions set forth in this plan effective October 1, 1989. Effective October 1, 1991, allowable costs will include all physician costs, excluding the professional component side of physician cost. The professional component side will be billed separately under the physician services line of the South Carolina Medicaid Program.

G. Payment Determination for ICF/MR's

1. All ICF/MR's shall apply the cost finding methods specified under 42 CFR 413.24(d) (1998) to its allowable costs for the cost reporting year under the South Carolina State Plan. ICF/MR facilities will not be subject to the allowable cost definitions V (A) through V (H) as defined in the plan.

2. All State owned/operated ICF/MR's are required to report costs on the Medicare Cost Reporting Form SSA 2552. For cost reporting periods beginning on or after July 1, 1986, all other ICF/MR's which are not operated by the State (S.C. Department of Disabilities and Special Needs) will file annual financial and statistical report forms supplied by the Medicaid Agency. All cost reports must be filed with the Medicaid Agency within one hundred twenty (120) days from close of each fiscal year.

3. ICF/MR's will be reimbursed on a retrospective cost related basis as determined in accordance with Medicare (Title XVIII) Laws, Regulations, and Policies adjusted for services covered by Medicaid (Title XIX).

Items of expense incurred by the ICF/MR facility in providing care are allowable costs for inclusion in the facility's cost report. These allowable costs are defined as items of expense which the provider may incur in meeting the definition of intermediate care or any expenses incurred in complying with state licensing or federal certification requirements.

Medicaid payment to the ICF/MR includes, but is not limited to, reimbursement for the following services:

1. Room and board including all of the items necessary to furnish the individual's room (luxury items/fixtures will not be recognized as an allowable cost). 42 CFR §483.470(b), (c), (d), (e), (f), and (g)(1) - (1998)

2. Direct care and nursing services as defined for each living unit of the facility. 42 CFR §483.460(c) - (1998)

3. Training and assistance as required for the activities of daily living, including, but not limited to, toileting, bathing, personal hygiene and eating as appropriate. 42 CFR §483.440(a) - (1998)

4. Walkers, wheelchairs, dental services, eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. If any of these services are reimbursable under a separate Medicaid program, the cost will be disallowed in the cost report (effective for cost reporting periods beginning July 1, 1989).

5. Maintenance in good repair of dentures, eyeglasses, hearing aids, braces, and other aids prescribed for a resident by an appropriate specialist effective for cost reporting periods beginning July 1, 1989. 42 CFR §483.470(g)(2) - (1998)

6. Therapy services including, but not limited to, speech, recreation, physical, and occupational, as prescribed by the resident's individual habilitation plan. 42 CFR §483.430(b) - (1998)

7. Transportation services as required to provide other services including vehicles with lifts or adaptive equipment, as needed. The cost of ambulance services will not be included as part of allowable costs.

8. Psychological services as described in 42 CFR §483.430(b)(1) and (b)(5)(v) - (1998).

9. Recreational services as described in 42 CFR §483.430(b)(1) and (b)(5)(viii) - (1998).

10. Social services as described in 42 CFR §483.430(b)(1) and (b)(5)(vi) - (1998).

11. Speech and hearing services as described in 42 CFR §483.430(b)(1) and (b)(5)(vii) - (1998).

12. Food and nutritional services as described in 42 CFR §483.480 - (1998).

13. Safety and sanitation services as described in 42 CFR §483.470(a), (g)(3), (h), (i), (j), (k), and (l) - (1998).

14. Physician services as described in 42 CFR §483.460(a) - (1998).

Any service (except for physician services) that is required of an ICF/MR facility that is reimbursable under a separate Medicaid program area must be billed to the respective program area. Any costs of this nature cannot be claimed in the Medicaid cost report.

4. Interim reimbursement rates for ICF/MR facilities will be calculated based upon cost projections submitted by the South Carolina Department of Disabilities and Special Needs for the fiscal year in which the rate is to be set. This will be done in order to avoid large year end final cost settlements and improve the cash flow of the participating ICF/MR facilities.

5. The Medicaid Agency will not pay more than the provider's customary charge except public facilities that provide services free or at a nominal charge. Reimbursement to public facilities will be limited in accordance with 42 CFR §447.271(b): (1998).

H. Payment for Swing-Bed Hospitals

Effective July 1, 1989, the South Carolina Medicaid Program will participate in the provision of nursing facility services in swing bed hospitals. A rate will be determined in accordance with the payment methodology as outlined in this state plan, adjusted for the following conditions:

A) Effective October 1, 1992, all nursing facilities in operation will be used in the calculation of the rate.

B) The rate excludes the cost associated with therapy services.

C) The rate reflects a weighted average rate using the state's prior FYE June 30 Medicaid permit days. Effective July 1, 1991, projected Medicaid days were used.

I. Intensive Technical Services Reimbursement

Effective July 1, 1989, an enhanced rate of $150 per patient day may be available for nursing facility recipients who require more intensive technical services (i.e., those recipients who have extreme medical conditions which requires total dependence on a life support system). Effective December 1, 1990, this rate will be $180. This rate was determined through an analysis of costs of 1) a small rural hospital located in South Carolina who would set up

a small ward to provide this level of service and 2) contracting with an out-of-state provider which has established a wing in a nursing facility to deliver this type of service. This set per diem rate will represent payment in full and will not be cost settled. Providers receiving payment for intensive technical services patients will be required to step down cost applicable to this nonreimbursable cost center in accordance with item I(C) of this plan, upon submission of their annual cost report.

J. Payment for Out-of-State Long Term Care Facilities

In order to provide services to the South Carolina Medicaid patients awaiting placement into a nursing facility, the agency will contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The agency will use the out-of-state facility's survey conducted by their survey and certification agency for our survey and certification purposes. Placement of a South Carolina Medicaid recipient into an out-of-state facility will only occur if a bed is unavailable in South Carolina. No year end South Carolina Medicaid long term care cost report will be required from the participating out-of-state facilities.

K. In accordance with 42 CFR 447.205 (1998) the public shall be given notice so they may have the opportunity to review and comment on proposed methods and standards of payment or any substantial changes in the methods and standards of payment before they become effective.

L. Payment Assistance

The Medicaid Agency will pay each Provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the Provider under the Plan according to the methods and standards set forth in Section III of this attachment.

M. Upper Limits

1) The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except public facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.

2) Any limitation on coverage of cost published under 42 CFR 413.30 (1998) and 413.35 (1998) will be applied to payments for long-term care facility services.

3) The cost of services, facilities and supplies furnished by organizations related by common ownership or control will not exceed the lower of the cost to the organization or the price of comparable services, facilities or supplies purchased elsewhere. The Medicaid Agency's cost report requires related organizations and costs to be identified and certified.

4) The Medicaid Agency may not pay more in the aggregate for long term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. If it is determined that SCDHHS is paying more in the aggregate for long term care services, then the Medicaid rate for each facility will be limited to the Medicare rate retroactive to the beginning of the contract period.

N. Provider Participation

Payments made under this State Plan are designed to enlist participation of a sufficient number of Providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public. In accordance with the Balanced Budget Act of 1997, the state has provided for a public process in which providers, beneficiaries and their representatives, and other concerned state residents are given the reasonable opportunity to review and comment on the determination of rates under this plan.

O. Payment in Full

Participation in the program shall be limited to Providers of services who accept, as payment in full, the amounts paid in accordance with the provisions of this attachment for covered services provided to Medicaid recipients in accordance with 42 CFR 447.15 (1998).

V. Allowability of Certain Costs

A) Auto Expense:

Allowable costs shall not include actual costs of administrative vehicles used for business purposes or regular vehicles used for patient care related activities (depreciation, maintenance, gas and oil, etc.). Allowable costs shall include administrative vehicle expense and regular vehicles expense used for patient care related activities only through documented business miles multiplied by the current mileage rate for the State of South Carolina employees.

Allowable costs shall include the actual costs of specialty vehicles (e.g., vans, trucks). These costs will be classified to the appropriate cost centers for Medicaid cost reporting purposes. Allowable costs would include operation, maintenance, gas and oil, and straight line depreciation (over a 5 year useful life). Should these specialty vehicles be made available for personal use of the facility employees, then that percentage of cost would be reclassified to nonallowable expense.

It is the intent of the SCDHHS to recognize as specialty vehicles, station wagons with a seating capacity of more than six (6) passengers used in patient care related activities, vans, and trucks. The cost of sedans or station wagons with a seating capacity of six (6) or less passengers used for patient transport or other patient care related activities will be limited to the state employee mileage rate and charged to the appropriate cost center(s) based upon miles documented by a log effective August 1, 1986.